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DEFENSE HEALTH CARE

DOD Lacks Assurance That Selected Reserve Members Are Informed about TRICARE Reserve Select



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DEFENSE HEALTH CARE

DOD Lacks Assurance That Selected Reserve Members Are Informed about TRICARE Reserve Select

Why GAO Did This Study

TRICARE Reserve Select (TRS) provides certain members of the Selected Reserve—reservists considered essential to wartime missions—with the ability to purchase health care coverage under the Department of Defense's (DOD) TRICARE program after their active duty coverage expires. TRS is similar to TRICARE Standard, a fee-for-service option, and TRICARE Extra, a preferred provider option.

The National Defense Authorization Act for Fiscal Year 2008 directed GAO to review TRS education and access to care for TRS beneficiaries. This report examines (1) how DOD ensures that members of the Selected Reserve are informed about TRS and (2) how DOD monitors and evaluates access to civilian providers for TRS beneficiaries. GAO reviewed and analyzed documents and evaluated an analysis of claims conducted by DOD. GAO also interviewed officials with the TRICARE Management Activity (TMA), the DOD entity responsible for managing TRICARE; the regional TRICARE contractors; the Office of Reserve Affairs; and the seven reserve components.

What GAO Recommends

GAO recommends that the Secretary of Defense direct the Assistant Secretary of Defense for Reserve Affairs to develop a policy requiring each reserve component to designate a centralized point of contact for TRS education. DOD partially concurred with this recommendation, citing a concern about regional coordination. GAO modified the recommendation.

View [GAO-11-551](#) or key components. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

DOD does not have reasonable assurance that Selected Reserve members are informed about TRS. A 2007 policy designated the reserve components as having responsibility for providing information about TRS to Selected Reserve members on an annual basis; however, officials from three of the seven components told GAO that they were unaware of this policy. Additionally, only one of the reserve components had a designated official at the headquarters level acting as a central point of contact for TRICARE education, including TRS. Without centralized responsibility for TRS education, the reserve components cannot ensure that all eligible Selected Reserve members are receiving information about the TRS program. Compounding this, the managed care support contractors that manage civilian health care are limited in their ability to educate all reserve component units in their regions as required by their contracts because they do not have access to comprehensive information about these units, and some units choose not to use the contractors to help educate their members about TRS. Nonetheless, DOD officials stated that they were satisfied with the contractors' efforts to educate units upon request and to conduct outreach. Lastly, it is difficult to determine whether Selected Reserve members are knowledgeable about TRS because the results of two DOD surveys that gauged members' awareness of the program may not be representative because of low response rates.

Because TRS is the same benefit as the TRICARE Standard and Extra options, DOD monitors access to civilian providers for TRS beneficiaries in conjunction with TRICARE Standard and Extra beneficiaries. DOD has mainly used feedback mechanisms, such as surveys, to gauge access to civilian providers for these beneficiaries in the absence of access standards for these options. GAO found that jointly monitoring access for these two beneficiary groups is reasonable because a claims analysis showed that TRS beneficiaries and TRICARE Standard and Extra beneficiaries had similar health care utilization. Also, during the course of GAO's review, TMA initiated other efforts that specifically evaluated access to civilian providers for the Selected Reserve population and TRS beneficiaries, including mapping the locations of Selected Reserve members in relation to areas with TRICARE provider networks.

Contents

Letter		1
	Background	5
	DOD Does Not Have Reasonable Assurance That Selected Reserve Members Are Informed about TRS	14
	DOD Monitors Access to Civilian Providers under TRS in Conjunction with Other TRICARE Options and Has Taken Steps to Evaluate Access Specifically for TRS	19
	Conclusions	23
	Recommendation for Executive Action	23
	Agency Comments and Our Evaluation	24
Appendix I	TRICARE Management Activity Analysis of Claims	25
Appendix II	Claims Filed for TRICARE Reserve Select and TRICARE Standard and Extra Beneficiaries	26
Appendix III	Comments from the Department of Defense	29
Appendix IV	GAO Contact and Staff Acknowledgments	31
Tables		
	Table 1: Summary of TRICARE Options	10
	Table 2: Percentage of Claims Filed for TRICARE Reserve Select (TRS) and TRICARE Standard and Extra Beneficiaries by Age of Beneficiary, Fiscal Years 2008 through 2010	26
	Table 3: Percentage of Claims Filed for TRICARE Reserve Select (TRS) and TRICARE Standard and Extra Beneficiaries by Mental Health Care, Primary Health Care, and Other Types of Specialty Care, Fiscal Years 2008 through 2010	26
	Table 4: Percentage of Claims Filed for TRICARE Reserve Select (TRS) and TRICARE Standard and Extra Beneficiaries by Top 10 Diagnoses in Ranking Order, Fiscal Years 2008 through 2010	27

Table 5: Percentage of Claims Filed for TRICARE Reserve Select (TRS) and TRICARE Standard and Extra Beneficiaries by Top Five Provider Specialties, Fiscal Years 2008 through 2010	28
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Figures

Figure 1: Number of Selected Reserve Members by Component as a Percentage of All Selected Reserve Members, December 31, 2010	6
Figure 2: Age and Marital Status of Selected Reserve Members, December 31, 2010	7
Figure 3: Cycle of TRICARE Coverage and Eligibility as of December 31, 2010	12
Figure 4: Proportion of Claims Filed by TRICARE Reserve Select and TRICARE Standard and Extra Beneficiaries for Mental Health, Primary, and Other Specialty Care, Fiscal Years 2008 through 2010	22

Abbreviations

DMDC	Defense Manpower Data Center
DOD	Department of Defense
FEHB	Federal Employees Health Benefits
NDAA	National Defense Authorization Act
TAMP	Transitional Assistance Management Program
TMA	TRICARE Management Activity
TRS	TRICARE Reserve Select

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United States Government Accountability Office
Washington, DC 20548

June 3, 2011

The Honorable Carl Levin
Chairman
The Honorable John McCain
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Howard P. “Buck” McKeon
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

Since the September 11, 2001, terrorist attacks, the Department of Defense (DOD) has increasingly relied on reservists to support military operations, such as the conflicts in Iraq and Afghanistan. This has increased both the number of Selected Reserve members—reservists who are considered essential to wartime missions—supporting DOD’s current operations and the duration of their active duty service.¹ In recognition of this, Congress has increased the health care benefits available to reservists and their dependents, which include spouses and dependent children. Specifically, the National Defense Authorization Acts (NDAA) for Fiscal Years 2004, 2005, 2006, 2007, and 2010 expanded the number of reservists (including Selected Reserve members) who qualify for TRICARE, the military health care program, and increased the period of time during which they qualify.² The NDAA for Fiscal Year 2005 also established the program that DOD has named TRICARE Reserve Select (TRS), under which most members of the Selected Reserve who are not on active duty may purchase TRICARE coverage after the coverage associated with active duty expires. TRS is the

¹For the purposes of this report, the term reservist includes all members of the seven reserve components, which include the Army National Guard, Army Reserve, Navy Reserve, Marine Corps Reserve, Air National Guard, Air Force Reserve, and Coast Guard. There are different categories of reservists within the seven reserve components. The Selected Reserve is the largest category of reservists among the components and has priority over all other categories of reservists.

²Prior to these expansions, a reservist and his or her dependents were eligible for TRICARE only while the reservist was serving on active duty for more than 30 days.

same benefit as TRICARE Standard, a fee-for-service option, and TRICARE Extra, a preferred provider option. All three programs cover health care provided at military treatment facilities and through civilian providers, both network (TRICARE Extra) and nonnetwork (TRICARE Standard).³ However, unlike TRICARE beneficiaries who use the Standard and Extra options, TRS enrollees must pay a monthly premium to receive benefits through the program.

In recent years, members of Congress have raised questions about whether reservists, including members of the Selected Reserve, and their dependents have adequate health insurance when they are not on active duty and whether they have difficulty using TRICARE when they are eligible for it. In 2007, we reported on several issues related to reservists, including DOD's efforts to educate reservists and their dependents about TRICARE benefits, reservists' satisfaction with TRICARE, and the types of problems that reservists and their dependents experienced when using TRICARE.⁴ We found that DOD was challenged by the task of educating reservists and their dependents about TRICARE, and we recommended that DOD provide additional briefings to reservists and their dependents at specific points in time. We also found that although a majority of reservists reported that they were satisfied with their TRICARE benefits, some reservists reported experiencing difficulties when using the program, including difficulties understanding TRICARE and difficulties finding a health care provider who accepted TRICARE beneficiaries as patients.

Subsequent to our report, the Commission on the National Guard and Reserves reported to Congress in 2008 that the TRICARE Management Activity (TMA)—the DOD entity responsible for overseeing TRICARE—and the military services have not undertaken a sufficiently aggressive educational campaign to help improve reservists' and their families' understanding of TRICARE.⁵ More recently, groups representing military

³Network providers are TRICARE-authorized providers who enter a contractual agreement to provide health care to TRICARE beneficiaries. Nonnetwork providers are TRICARE-authorized providers who do not have a contractual agreement to provide care to TRICARE beneficiaries. All beneficiaries may obtain care at military treatment facilities although priority is first given to any active duty personnel and then to beneficiaries using TRICARE Prime, another TRICARE option, which requires the beneficiary to enroll.

⁴GAO, *Military Health: Increased TRICARE Eligibility for Reservists Presents Educational Challenges*, [GAO-07-195](#) (Washington, D.C.: Feb. 12, 2007).

⁵Commission on the National Guard and Reserves, *Transforming the National Guard and Reserves into a 21st-Century Operational Force: Final Report to Congress and the Secretary of Defense* (Washington D.C., 2008).

beneficiaries told us that they were concerned about low enrollment within the TRS program, and they questioned whether these enrollment numbers are the result of inadequate education by DOD. According to DOD officials, as of December 2010 about 392,000 of the more than 858,000 members of the Selected Reserve were eligible for TRS.⁶ Of these, about 67,000 members (17 percent) had purchased TRS.

Concerns have also been expressed about the ability of reservists, including members of the Selected Reserve, and their families to access health care. In June 2007, DOD's Task Force on Mental Health reported that because reservists may not live near military installations like their active duty counterparts, they may not have convenient access to military hospitals and clinics and must instead rely more heavily on civilian providers for their care.⁷

The NDAA for Fiscal Year 2008 directed us to review DOD's efforts to educate members of the Selected Reserve about TRS and access to care for TRS beneficiaries.⁸ This report examines (1) how DOD ensures that members of the Selected Reserve are informed about TRS and (2) how DOD monitors and evaluates access to civilian providers for TRS beneficiaries.

To examine how DOD ensures that members of the Selected Reserve are informed about TRS and how DOD monitors and evaluates access to civilian providers for TRS beneficiaries, we interviewed officials with TMA, including officials with the Warrior Support Branch, which oversees TRS, and officials with the Communications and Customer Service Division, which develops educational materials for TRICARE. We also interviewed officials from each of the three TRICARE Regional Offices (North, South, and West) and officials from each of the regional managed care support contractors (contractors) to discuss their responsibilities for

⁶To qualify for TRS, a member of the Selected Reserve of a reserve component must not be eligible for or enrolled in the Federal Employees Health Benefits (FEHB) Program either under his or her own eligibility or through a family member. See 10 U.S.C. § 1076d. All National Guard and Reserve manpower is assigned to one of three reserve component categories—the Ready Reserve, the Standby Reserve, and the Retired Reserve. 10 U.S.C. § 10141(a). The Selected Reserve is a component of the Ready Reserve. Once activated to duty, National Guard and Reserve servicemembers are eligible for TRICARE Prime.

⁷Department of Defense, Task Force on Mental Health, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health* (Falls Church, Va., June 2007).

⁸Pub. L. No. 110-181, § 711(b)(2)(G), (H), 122 Stat. 3, 192 (2008).

educating members of the Selected Reserve about TRICARE, including TRS, and for ensuring beneficiaries' access to civilian providers. In addition, we interviewed officials from military coalition groups that represent reservists to obtain their perspectives on TRS education and access to civilian providers. To identify TRS education requirements, we reviewed and analyzed policy guidelines and TRICARE managed care support contract requirements. We interviewed officials with the Office of Reserve Affairs as well as officials from each of the seven reserve components to identify their role in educating the Selected Reserve about TRICARE. We also reviewed relevant standards for internal control in the federal government.⁹ Additionally, we evaluated two surveys conducted by DOD that collected information on whether members of the Selected Reserve were aware of the TRS program—the Status of Forces Survey and the *Focused Survey of TRICARE Reserve Select and Selected Reserve Military Health System Access and Satisfaction*.

To determine how DOD monitors and evaluates access to civilian providers for TRS, we reviewed TMA's beneficiary surveys on access to civilian providers under TRICARE Standard, TRICARE Extra, and TRS. We also reviewed the TRICARE Regional Offices' recent efforts to evaluate the adequacy of access to civilian providers under the TRICARE Standard, TRICARE Extra, and TRS options. Additionally, we evaluated an analysis of claims conducted by TMA—at our request—that compared claims filed by TRICARE Standard and Extra beneficiaries with those filed by TRS beneficiaries for fiscal years 2008 through 2010 to identify demographic differences between these populations and to determine whether these populations used similar types of providers and obtained similar types of care. We assessed the reliability of these data by speaking with knowledgeable officials and reviewing related documentation, and we determined that the claims analyses presented in this report are sufficiently reliable for our purposes. (See app. I for more detail about the claims analyses.) We also reviewed efforts by TMA to identify locations of the Selected Reserve members and analyze whether they resided within an area that was served by a TRICARE provider network. Finally, we

⁹Standards for internal control in the federal government state that agency management is responsible for establishing and maintaining a control environment that sets a positive attitude toward internal control and conscientious management, including an organizational structure with clearly defined areas of authority and responsibility. See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999), and *Internal Control Management and Evaluation Tool*, [GAO-01-1008G](#) (Washington, D.C.: August 2001).

reviewed TMA's efforts to repeat its survey that is specific to the TRS program (*Focused Survey of TRICARE Reserve Select and Selected Reserve Military Health System Access and Satisfaction*).

We conducted this performance audit from July 2010 through June 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

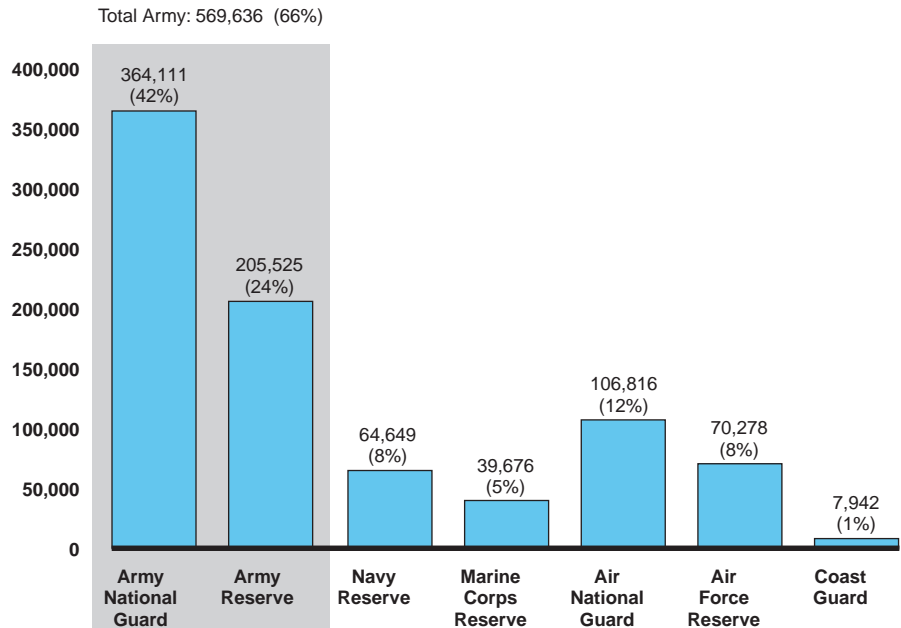
Reservists are members of the seven reserve components, which provide trained and qualified persons available for active duty in the armed forces in time of war or national emergency. The Selected Reserve is the largest category of reservists and is designated as essential to wartime missions.¹⁰ The Selected Reserve is also the only category of reservists that is eligible for TRS. As of December 31, 2010, the Selected Reserve included 858,997 members dispersed among the seven reserve components with about two-thirds belonging to the Army Reserve and the Army National Guard.¹¹ See figure 1 for the number and percentage of Selected Reserve members within each reserve component.

¹⁰The other reserve categories are the Individual Ready Reserve, Standby Reserve, and Retired Reserve.

¹¹According to officials, this number is not the official strength of the Selected Reserve.

Figure 1: Number of Selected Reserve Members by Component as a Percentage of All Selected Reserve Members, December 31, 2010

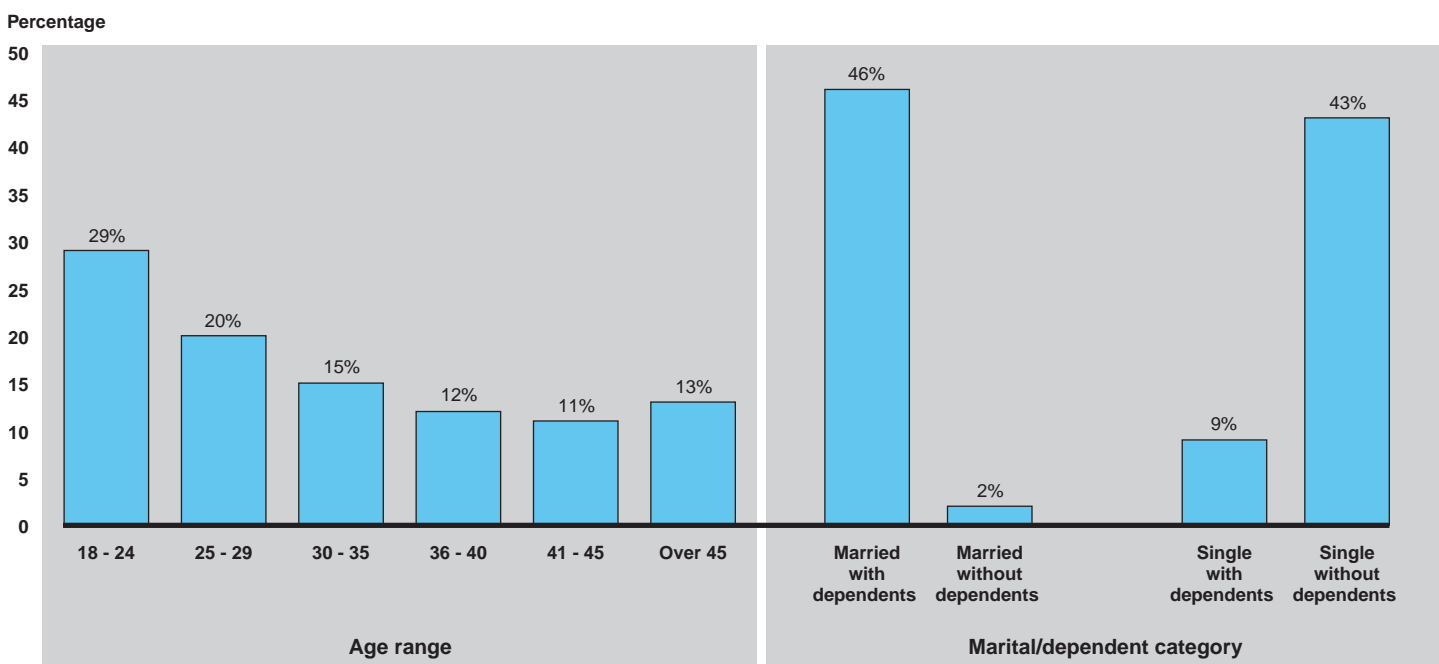
Number of Selected Reserve members



Source: GAO analysis of Department of Defense data.

Additionally, about two-thirds of the Selected Reserve members are 35 years old or younger (64 percent) and about half are single (52 percent). (See fig. 2.)

Figure 2: Age and Marital Status of Selected Reserve Members, December 31, 2010



Source: GAO analysis of Department of Defense data.

History of TRS

The NDAA for Fiscal Year 2005 authorized the TRS program and made TRICARE coverage available to certain members of the Selected Reserve.¹² The program was subsequently expanded and restructured by the NDAs for Fiscal Years 2006 and 2007¹³—although additional program changes were made in subsequent years.¹⁴

- In fiscal year 2005, to qualify for TRS, members of the Selected Reserve had to enter into an agreement with their respective reserve components to continue to serve in the Selected Reserve in exchange for TRS coverage,

¹²See Pub. L. No. 108-375, § 701, 118 Stat. 1811, 1980-82 (2004).

¹³See Pub. L. No. 109-163, §§ 701-702, 119 Stat. 3136, 3339-42 (2006); Pub. L. No. 109-364, § 706, 120 Stat. 2083, 2282 (2006).

¹⁴For example, the NDAA for Fiscal Year 2009 specified that the appropriate actuarial basis for calculating TRS premiums should utilize the actual cost of providing benefits to TRS members and their dependents in preceding calendar years beginning with calendar year 2010.

and they were given 1 year of TRS eligibility for every 90 days served in support of a contingency operation.¹⁵

- The NDAA for Fiscal Year 2006, which became effective on October 1, 2006, expanded the program, and almost all members of the Selected Reserve and their dependents—regardless of their prior active duty service—had the option of purchasing TRICARE coverage through a monthly premium. The portion of the premium paid by the members of the Selected Reserve and their dependents for TRS coverage varied based on certain qualifying conditions that had to be met, such as whether the member of the Selected Reserve also had access to an employer-sponsored health plan. The NDAA for Fiscal Year 2006 established two levels—which DOD called tiers—of qualification for TRS, in addition to the tier established by the NDAA for Fiscal Year 2005, with enrollees paying different portions of the premium based on the tier for which they qualified.¹⁶
- The NDAA for Fiscal Year 2007 significantly restructured the TRS program by eliminating the three-tiered premium structure and establishing open enrollment for members of the Selected Reserve provided that they are not

¹⁵ A contingency operation is a military operation that is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing force or a military operation that results in the call-up to (or retention on) active duty of members of the uniformed Services under certain statutes during war or a national emergency declared by the President or Congress.

¹⁶ For tier one, a reservist must have had qualifying active duty service in support of a contingency operation on or after September 11, 2001, for at least 90 days and must have agreed to serve in the Selected Reserve for the entire period of TRS coverage. The reservist must have executed this service agreement within 90 days after release from active duty. The reservist was responsible for paying 28 percent of the premium. For tier two a reservist who did not qualify for tier one must not have been eligible for employer-sponsored health insurance, or must have been eligible for unemployment compensation, or must have been self-employed, and must have executed a service agreement to serve in the Selected Reserve for the entire period of TRS coverage. The reservist must have qualified during open season or submitted documentation establishing a qualifying life event. The reservist was responsible for paying 50 percent of the premium. For tier three, a reservist who did not qualify for tier one or two may have been eligible for employer-sponsored insurance, but must have executed a service agreement to serve in the Selected Reserve for the entire period of TRS coverage. The reservist must have qualified during open season or submitted documentation establishing a qualifying life event. The reservist was responsible for paying 85 percent of the premium.

eligible for or currently enrolled in the FEHB Program.¹⁷ The act removed the requirement that members of the Selected Reserve sign service agreements to qualify for TRS. Instead, the act established that members of the Selected Reserve qualify for TRS for the duration of their service in the Selected Reserve. DOD implemented these changes on October 1, 2007.

TRICARE Options and Cycle of Coverage for the Selected Reserve

Generally, TRICARE provides its benefits through several options for its non-Medicare-eligible beneficiary population.¹⁸ These options vary according to TRICARE beneficiary enrollment requirements, the choices TRICARE beneficiaries have in selecting civilian and military treatment facility providers, and the amount TRICARE beneficiaries must contribute toward the cost of their care. Table 1 provides information about these options.

¹⁷The NDAA for Fiscal Year 2008, provided that certain members of the Selected Reserve, who were eligible for the FEHB Program, could continue to receive benefits under their previous tier 1 TRS agreement despite FEHB eligibility.

¹⁸Retirees and certain dependents and survivors who are entitled to Medicare Part A and enrolled in Part B, and who are generally age 65 and older, are eligible to obtain care under a separate program called TRICARE for Life. TRICARE for Life is a program that supplements Medicare coverage for Medicare-eligible beneficiaries enrolled in Medicare Part B. TRICARE beneficiaries under 65 years of age who are eligible for Medicare Part A on the basis of disability or end-stage renal disease are eligible for TRICARE for Life if they enroll in Medicare Part B.

Table 1: Summary of TRICARE Options

TRICARE option	Description
TRICARE Prime	Active duty servicemembers are required to enroll in this managed care option while other TRICARE beneficiaries may choose to enroll in this option. TRICARE Prime enrollees receive most of their care from providers at military treatment facilities, augmented by network civilian providers. TRICARE Prime offers lower out-of-pocket costs than the other TRICARE options. It is also the only option with access standards, which include appointment wait times and travel times.
TRICARE Standard and TRICARE Extra	TRICARE beneficiaries, who are not on active duty, who choose not to enroll in TRICARE Prime may obtain health care from nonnetwork civilian providers (under TRICARE Standard) or network civilian providers (under TRICARE Extra). Under TRICARE Extra, beneficiaries have lower cost-shares than they would have under the TRICARE Standard option—about 5 percentage points less for using network providers.
TRICARE Reserve Select (TRS)	TRS is a premium-based health plan that certain members of the Selected Reserve, who are not on active duty, may purchase. Under TRS, beneficiaries may obtain health care from either nonnetwork or network civilian providers, similar to beneficiaries using TRICARE Standard or Extra, respectively, and will pay lower cost-shares for using network providers.

Source: GAO summary of Department of Defense TRICARE documentation.

Note: All beneficiaries may obtain care at military treatment facilities although priority is first given to active duty personnel and then TRICARE Prime enrollees.

Selected Reserve members have a cycle of coverage during which they are eligible for different TRICARE options based on their duty status—preactivation, active duty, deactivation, and inactive. During preactivation, when members of the Selected Reserve are notified that they will serve on active duty in support of a contingency operation in the near future, they and their families are eligible to enroll in TRICARE Prime, and therefore, they do not need to purchase TRS coverage.¹⁹ This is commonly referred to as “early eligibility” and continues uninterrupted once members of the Selected Reserve begin active duty. While on active duty, members are required to enroll in TRICARE Prime. Similarly during deactivation, for 180 days after returning from active duty in support of a contingency operation, members of the Selected Reserve are rendered eligible for the Transitional Assistance Management Program, a program to transition back to civilian life in which members and dependents can use the TRICARE Standard or Extra options.²⁰ When members of the Selected

¹⁹For members activated not in support of a contingency operation, TRICARE coverage becomes effective when active duty starts.

²⁰Members activated not in support of a contingency operation are not eligible for the Transitional Assistance Management Program and return to inactive status immediately after returning from active duty.

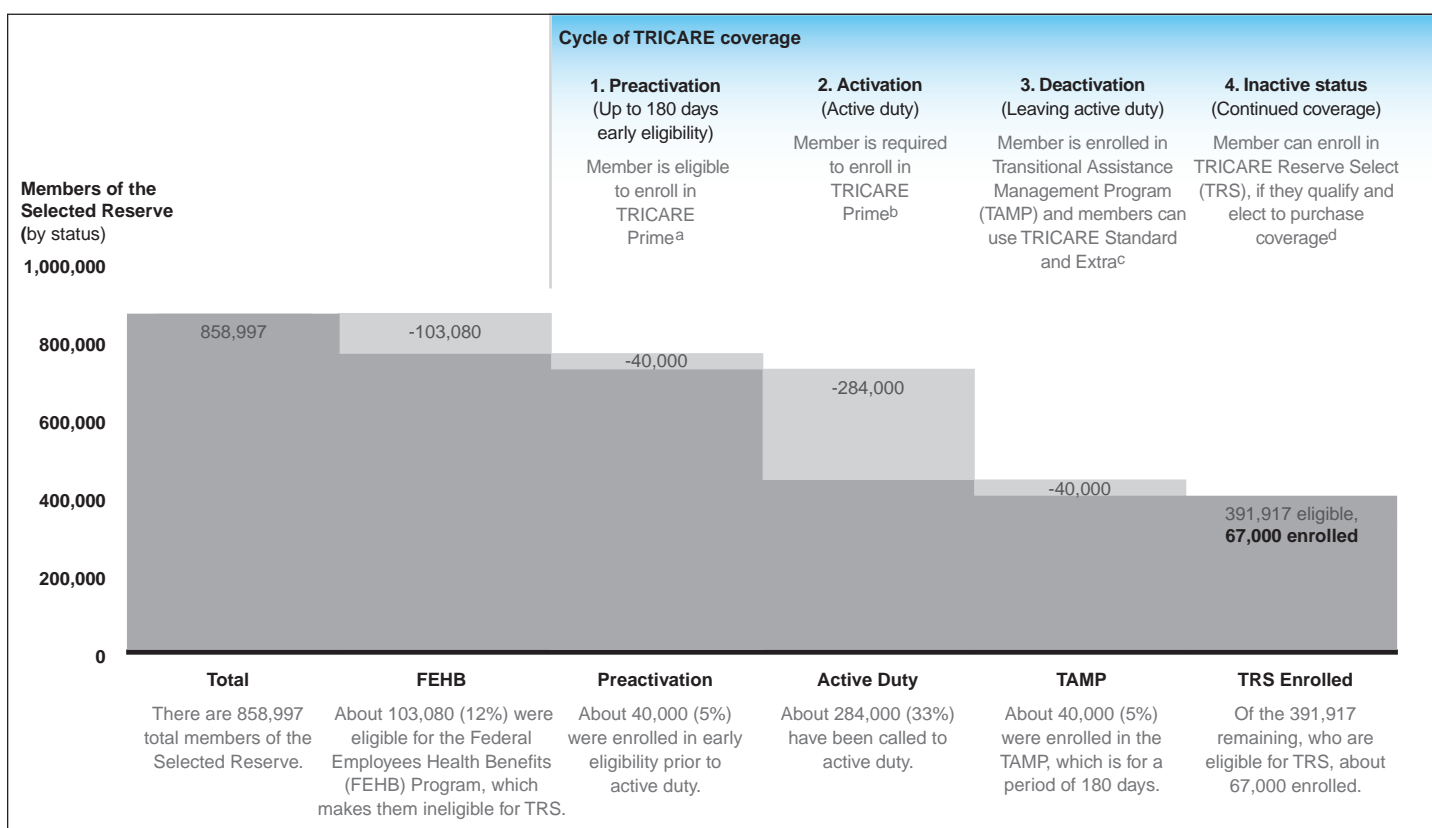
Reserve return to inactive status, they can choose to purchase TRS coverage if eligible.

As a result of the TRICARE coverage cycle and program eligibility requirements, TMA officials estimate that at any given time, fewer than half of the members of the Selected Reserve are qualified to purchase TRS. Currently, to qualify for TRS, a member of the Selected Reserve must not

- be eligible for the FEHB Program,
- have been notified that he or she will serve on active duty in support of a contingency operation, and
- be serving on active duty or have recently, that is, within 180 days, returned from active duty in support of a contingency operation.

Of the more than 390,000 members eligible, about 67,000 members were enrolled in TRS as of December 31, 2010. (See fig. 3.)

Figure 3: Cycle of TRICARE Coverage and Eligibility as of December 31, 2010



Source: GAO analysis of Department of Defense data.

^aIf a Selected Reserve member was enrolled in TRS prior to preactivation, the member is automatically disenrolled at this time. Even if a member does not enroll, the member will receive TRICARE benefits. In addition, at this time, members and their families begin receiving the same care as active duty servicemembers and their families. This is applicable when a member of the Selected Reserve is called to active duty for more than 30 days and is serving in support of a contingency operation.

^bEven if a member does not enroll he or she will still receive TRICARE Prime benefits.

^cTAMP is applicable when a member of the Selected Reserve is called to active duty for more than 30 days and is serving in support of a contingency operation. TRICARE Prime is available in specific locations.

^dIf a member was enrolled in TRS prior to serving on active duty, the member must reenroll after returning to inactive status. Members are not automatically reenrolled in TRS; they must requalify and purchase TRS again. In addition, the cycle repeats once a Selected Reserve member is called to active duty.

DOD Entities Involved with TRS

A number of different DOD entities have various responsibilities related to TRS.

- Within the Office of the Under Secretary of Defense for Personnel and Readiness, the Office of the Assistant Secretary of Defense for Reserve Affairs works with the seven reserve components to determine whether members of the Selected Reserve are eligible for TRS and to ensure that members have information about TRICARE, including TRS.
- Within TMA, the Warrior Support Branch is responsible for managing the TRS option, which includes developing policy and regulations. This office also works with TMA's Communication and Customer Service Division to develop educational materials for this program. The Assistant Secretary of Defense for Health Affairs oversees TMA and reports to the Under Secretary of Defense for Personnel and Readiness.
- TMA works with contractors to manage civilian health care and other services in each TRICARE region (North, South, and West).²¹ The contractors are required to establish and maintain sufficient networks of civilian providers within certain designated areas, called Prime Service Areas, to ensure access to civilian providers for all TRICARE beneficiaries, regardless of enrollment status or Medicare eligibility.²² They are also responsible for helping TRICARE beneficiaries locate providers and for informing and educating TRICARE beneficiaries and providers on all aspects of the TRICARE program, including TRS.
- TMA's TRICARE Regional Offices, located in each of the three TRICARE regions, are responsible for managing health care delivery for all TRICARE options in their respective geographic areas and overseeing the contractors, including monitoring network quality and adequacy, monitoring customer satisfaction outcomes, and coordinating appointment and referral management policies.

²¹The current managed care support contracts are the second generation of TRICARE contracts and the implementation period for these contracts was set to end on March 31, 2010, with the third generation of contracts to begin on April 1, 2010. However, this timeline was delayed because of bid protests on two of the three contracts.

²²Prime Service Areas are determined by the Assistant Secretary of Defense for Health Affairs and are defined by a set of five-digit zip codes, usually within an approximate 40-mile radius of a military inpatient treatment facility. However, the contractors were allowed to offer expanded or additional Prime Service Areas beyond the 40-mile radius.

DOD Does Not Have Reasonable Assurance That Selected Reserve Members Are Informed about TRS

DOD does not have reasonable assurance that members of the Selected Reserve are informed about TRS for several reasons. First, the reserve components do not have a centralized point of contact to ensure that members are educated about the program. Second, the contractors are challenged in their ability to educate the reserve component units in their respective regions because they do not have comprehensive information about the units in their areas of responsibility. And, finally, DOD cannot say with certainty whether Selected Reserve members are knowledgeable about TRS because the results of two surveys that gauged members' awareness of the program may not be representative of the Selected Reserve population because of low response rates.

Reserve Components Are Responsible for Providing Information about TRS to Selected Reserve Members, but Most Components Have Not Established Centralized Accountability for TRS Education

A 2007 policy from the Under Secretary of Defense for Personnel and Readiness designated the reserve components as having responsibility for providing information about TRS to members of the Selected Reserve at least once a year. When the policy was first issued, officials from the Office of Reserve Affairs—who have oversight responsibility for the reserve components—told us that they met with officials from each of the reserve components to discuss how the components would fulfill this responsibility. However, according to officials from the Office of Reserve Affairs, they have not met with the reserve components since 2008 to discuss how the components are fulfilling their TRS education responsibilities under the policy. These officials explained that they have experienced difficulties identifying a representative from each of the reserve components to attend meetings about TRS education. When we contacted officials from all seven reserve components to discuss TRS education, we had similar experiences. Three of the components had difficulties providing a point of contact. In fact, two of the components took several months to identify an official whom we could speak with about TRS education, and the other one had difficulties identifying someone who could answer our follow-up questions when our original point of contact was no longer available. Furthermore, officials from three of the seven components told us that they were not aware of this policy.

Regardless of their knowledge of the 2007 policy, officials from all of the reserve components told us that education responsibilities are delegated to their unit commanders. These responsibilities include informing members about their health options, which would include TRS. All of the components provide various means of support to their unit commanders

to help fulfill this responsibility.²³ For example, three of the components provide information about TRICARE directly to their unit commanders or the commanders' designees through briefings. The four other components provide information to their unit commanders through other means, such as policy documents, Web sites, and newsletters.

Additionally, while most of the components had someone designated to answer TRICARE benefit questions, only one of the reserve components had an official at the headquarters level designated as a central point of contact for TRICARE education, including TRS.²⁴ This official told us that he was unaware of the specific 2007 TRS education policy; however, he said his responsibilities for TRS education include developing annual communication plans, providing briefings to unit commanders, and publishing articles in the Air Force magazine about TRS. Designating a point of contact is important because a key factor in meeting standards for internal control in federal agencies is defining and assigning key areas of authority and responsibility—such as a point of contact for a specific policy. Without a point of contact to ensure that this policy is implemented, the reserve components are running the risk that some of their Selected Reserve members may not be receiving information about the TRS program—especially since some of the reserve component officials we met with were unaware of the policy.

²³A unit commander exercises authority over subordinates within a unit by virtue of rank or assignment. A commander has the authority and responsibility for effectively using available resources and for planning the employment of, organizing, directing, coordinating, and controlling military forces for the accomplishment of assigned missions. Within the reserve components, the unit under the control of the commander can consist of any number of servicemembers organized hierarchically into groups of various sizes for functional, tactical, and administrative purposes.

²⁴Officials from a second reserve component stated that they have a staff member who maintains information on a Web site about TRICARE; however, this person does not serve as a central point of contact for TRS education.

TRICARE Contractors Are Challenged in Their Ability to Annually Brief Reserve Component Units about TRS Because They Lack Comprehensive Information about the Units

The TRICARE contractors are required to provide an annual briefing about TRS to each reserve component unit in their regions, including both Reserve and National Guard units. All three contractors told us that they maintain education representatives who are responsible for educating members of the Selected Reserve on TRS. These representatives conduct unit outreach and provide information to members of the Selected Reserve at any time during predeployment and demobilization, at family events, and during drill weekends. The contractors use briefing materials maintained by TMA and posted on the TRICARE Web site. In addition to conducting briefings, the three contractors have increased their outreach efforts in various ways, including creating an online tutorial that explains TRS, mailing TRS information to Selected Reserve members, and working closely with Family Program coordinators to provide TRS information to family members.

However, the contractors are challenged in their ability to meet their requirement for briefing all units annually. First, they typically provide briefings to units upon request because this approach is practical based upon units' schedules and availability. For example, officials from one contractor told us that even though they know when geographically dispersed units will be gathering in one location, these units have busy schedules and may not have time for the contractor to provide a briefing. Each contractor records the briefings that are requested, when the briefing requests were fulfilled and by whom, and any questions or concerns that resulted from the briefings. However, some unit commanders do not request briefings from the contractors. For example, officials with one reserve component told us that they do not rely on the contractor to brief units because they were unaware that the contractors provided this service. In addition, these officials as well as officials from another reserve component told us that they did not know if their unit commanders were aware that they could request briefings from the contractors. All of the contractors told us that they conduct outreach to offer information to some of the units that have not requested a briefing, including both calling units to offer a briefing and providing materials. They added that more outreach is conducted to National Guard units because they are able to obtain information about these units from state officials. The TRICARE Regional Offices also told us that they conduct outreach to units to let them know that the contractor is available to brief the units about TRS. However, even though the contractor and the TRICARE Regional Offices conduct outreach to a unit, it does not necessarily mean that the unit will request a briefing.

Furthermore, while contractors are aware of some units in their regions, they do not have access to comprehensive lists of all reserve component units in their regions because the Web site links containing unit information that TMA originally provided to the contractors have become inactive. As a result, the contractors are not able to verify whether all units in their regions have received briefings. Officials from the Office of Reserve Affairs told us that reserve components report unit information to the Defense Manpower Data Center (DMDC), which maintains personnel information about all members of the military. However, these officials raised concerns about the accuracy of this information because it could be about 3 to 6 months old and may not be comprehensive. Officials at the Office of Reserve Affairs told us that the reserve components would likely have more up-to-date information about their units as they are responsible for reporting this information to DMDC. However, officials from TMA, the TRICARE Regional Offices, and contractors also told us that a comprehensive list of units would be difficult to maintain because the unit structure changes frequently.

Despite the challenges contractors face, officials with TMA's Warrior Support Branch told us that they are satisfied with the contractors' efforts to provide TRS briefings to the reserve component units in their regions. However, because officials do not know which units have been briefed on the program, there is a risk that some reserve component members are not receiving sufficient information on TRS and may not be taking advantage of coverage available to them.

DOD Has Conducted Surveys That Gauge TRS Awareness, but the Results May Not Be Representative

DOD has conducted two surveys that gauge whether members of the Selected Reserve are aware of TRS, among other issues. In 2008, TMA conducted the *Focused Survey of TRICARE Reserve Select and Selected Reserve Military Health System Access and Satisfaction* to better understand reserve component members' motivation for enrolling in TRS and to compare TRS enrollees' satisfaction with and access to health care services with that of other beneficiary groups.²⁵ In reporting the results of

²⁵This survey was based on the Health Care Survey of Department of Defense Beneficiaries, which was designed to provide a comprehensive look at beneficiary opinions about their DOD health care benefits. Members of the Selected Reserve are included in this survey. Officials told us that over time they have analyzed responses from members of the Selected Reserve and these responses were the impetus behind conducting this focused survey in 2008. TMA officials are currently repeating the *Focused Survey of TRICARE Reserve Select and Selected Reserve Military Health System Access and Satisfaction*.

this survey to Congress in February 2009, TMA stated that lack of awareness was an important factor in why eligible members of the Selected Reserve did not enroll in TRS.²⁶ TMA also reported that less than half of the eligible Selected Reserve members who were not enrolled in TRS were aware of the program.²⁷ However, the survey's response rate was almost 18 percent, and such a low response rate decreases the likelihood that the survey results were representative of the views and characteristics of the Selected Reserve population. According to the Office of Management and Budget's standards for statistical surveys, a nonresponse analysis is recommended for surveys with response rates lower than 80 percent to determine whether the responses are representative of the surveyed population. Accordingly, TMA conducted a nonresponse analysis to determine whether the survey responses it received were representative of the surveyed population, and the analysis identified substantial differences between the original respondents and the follow-up respondents. As a result of the differences found in the nonresponse analysis, TMA adjusted the statistical weighting techniques for nonresponse bias and applied the weights to the data before drawing conclusions and reporting the results.

DMDC conducts a quarterly survey, called the Status of Forces Survey, which is directed to all members of the military services. DMDC conducts several versions of this survey, including a version for members of the reserve components. This survey focuses on different issues at different points in time. For example, every other year the survey includes questions on health benefits, including questions on whether members of the reserve components are aware of TRICARE, including TRS. In July 2010, we issued a report raising concerns about the reliability of DOD's Status of Forces Surveys because they generally have a 25 to 42 percent response rate, and DMDC has not been conducting nonresponse analyses to determine whether the surveys' results are representative of the target population.²⁸ We recommended that DMDC develop and implement guidance both for conducting a nonresponse analysis and using the results

²⁶Department of Defense, TRICARE Management Activity, *Evaluation of the TRICARE Program: Fiscal Year 2009 Report to Congress* (Washington D.C., 2009).

²⁷Access to more affordable civilian options and opportunities to obtain civilian health insurance also affected the decision not to enroll.

²⁸GAO, *Human Capital: Quality of DOD Status of Forces Surveys Could Be Improved by Performing Nonresponse Analysis of the Results*, [GAO-10-751R](#) (Washington, D.C.: July 12, 2010).

of this analysis to inform DMDC's statistical weighting techniques, as part of the collection and analysis of the Status of Forces Survey results. DOD concurred with this recommendation, but as of January 2011, had not implemented it.

DOD Monitors Access to Civilian Providers under TRS in Conjunction with Other TRICARE Options and Has Taken Steps to Evaluate Access Specifically for TRS

DOD monitors access to civilian providers under TRS in conjunction with monitoring efforts related to the TRICARE Standard and Extra options. In addition, during the course of our review, TMA initiated additional efforts that specifically examine access to civilian providers for TRS beneficiaries and the Selected Reserve population, including mapping the locations of Selected Reserve members in relation to areas with TRICARE provider networks.

DOD Monitors Access to Civilian Providers for TRS Beneficiaries along with TRICARE Standard and Extra Beneficiaries

Because TRS is the same benefit as the TRICARE Standard and Extra options, DOD monitors TRS beneficiaries' access to civilian providers as a part of monitoring access to civilian providers for beneficiaries who use TRICARE Standard and Extra. As we have recently reported, in the absence of access-to-care standards for these options, TMA has mainly used feedback mechanisms to gauge access to civilian providers for these beneficiaries.²⁹ For example, in response to a mandate included in the NDAA for Fiscal Year 2008, DOD has completed 2 years of a multiyear survey of beneficiaries who use the TRICARE Standard, TRICARE Extra, and TRS options and 2 years of its second multiyear survey of civilian providers. Congress required that these surveys obtain information on access to care and that DOD give a high priority to locations having high concentrations of Selected Reserve members. In March 2010, we reported that TMA generally addressed the methodological requirements outlined in the mandate during the implementation of the first year of the multiyear

²⁹GAO, *Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra*, [GAO-11-500](#) (Washington, D.C.: June 2, 2011).

surveys.³⁰ While TMA did not give a high priority to locations with high concentrations of Selected Reserve members, TMA's methodological approach over the 4-year survey period will cover the entire United States, including areas with high concentrations of Selected Reserve members.

In February 2010, TMA directed the TRICARE Regional Offices to monitor access to civilian providers for TRICARE Standard, TRICARE Extra, and TRS beneficiaries through the development of a model that can be used to identify geographic areas where beneficiaries may experience access problems. As of May 2010, each of the TRICARE Regional Offices had implemented an initial model appropriate to its region. These models include, for example, data on area populations, provider types, and potential provider shortages for the general population. Officials at each regional office said that their models are useful but noted that they are evolving and will be updated.

To determine whether jointly monitoring access to civilian providers for TRS beneficiaries along with TRICARE Standard and Extra beneficiaries was reasonable, we asked TMA to perform an analysis of claims (for fiscal years 2008, 2009, and 2010) to identify differences in age demographics and health care utilization between these beneficiary groups. This analysis found that although the age demographics for these populations were different—more than half of the TRS beneficiaries were age 29 and under, while more than half of the TRICARE Standard and Extra beneficiaries were over 45—both groups otherwise shared similarities with their health care utilization.³¹ Specifically, both beneficiary groups had similar diagnoses, used the same types of specialty providers, and used similar proportions of mental health care, primary care, and specialty care. (See fig. 4.) Specifically:

- Seven of the top 10 diagnoses for both TRS and TRICARE Standard and Extra beneficiaries were the same. Three of these diagnoses—allergic

³⁰For additional information on how TMA generally addressed the methodological requirements, see GAO, *Defense Health Care: 2008 Access to Care Surveys Indicate Some Problems, but Beneficiary Satisfaction Is Similar to Other Health Plans*, [GAO-10-402](#) (Washington, D.C.: Mar. 31, 2010).

³¹For the purpose of this analysis, claims consist of all services provided by a professional, including a doctor or nurse, and do not include services submitted by an institution. In addition, these claims do not include inpatient care, medical supplies, or pharmacy claims.

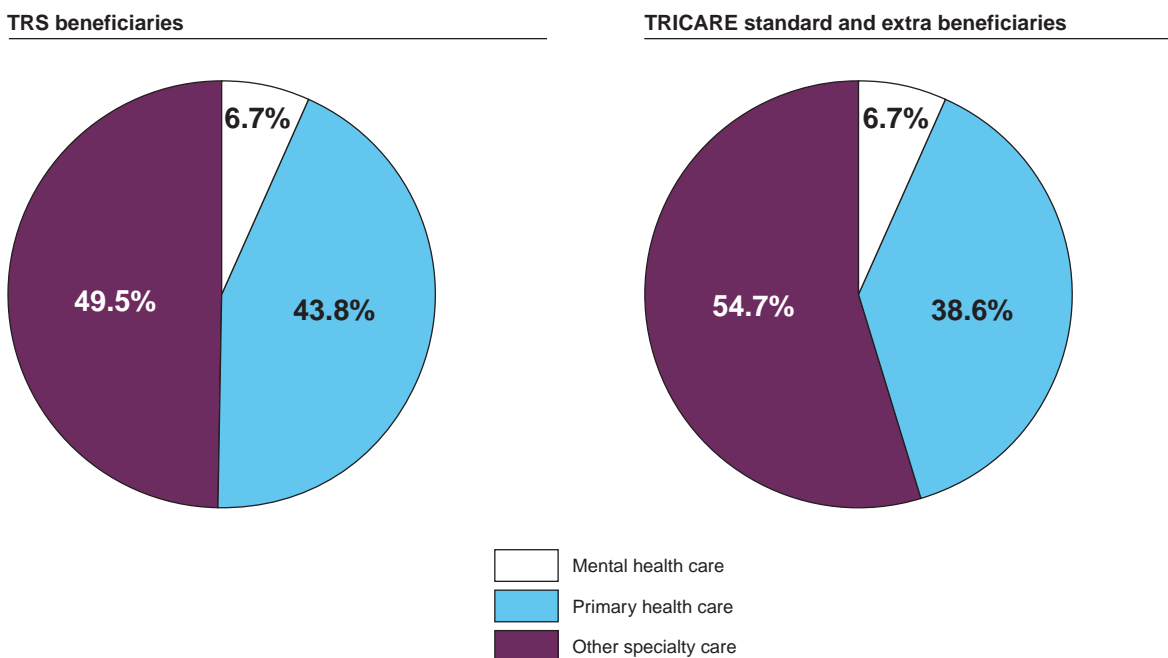
rhinitis,³² joint disorder, and back disorder—made up more than 20 percent of claims for both beneficiary groups.

- The five provider specialties that filed the most claims for both beneficiary groups were the same—family practice, physical therapy, allergy, internal medicine, and pediatrics. Furthermore, the majority of claims filed for both beneficiary groups were filed by family practice providers.
- Both beneficiary groups had the same percentage of claims filed for mental health care and similar percentages for primary care and other specialty care. (See app. II for additional details on the results of this claims analysis.)

Based on this analysis, jointly monitoring access for TRS beneficiaries and TRICARE Standard and Extra beneficiaries appears to be a reasonable approach.

³²Allergic rhinitis is a collection of symptoms, mostly in the nose and eyes, which occur when a person breathes in something the person is allergic to, such as dust, dander, or pollen.

Figure 4: Proportion of Claims Filed by TRICARE Reserve Select and TRICARE Standard and Extra Beneficiaries for Mental Health, Primary, and Other Specialty Care, Fiscal Years 2008 through 2010



Source: GAO analysis of TRICARE Management Activity data.

DOD Has Taken Steps to Separately Evaluate Access to Civilian Providers for the Selected Reserve Population and TRS Beneficiaries

DOD has taken steps to evaluate access to civilian providers for the Selected Reserve population and TRS beneficiaries separately from other TRICARE beneficiaries. Specifically, during the course of our review, TMA initiated the following efforts:

- During the fall of 2010, TMA officials analyzed the locations of Selected Reserve members and their families, including TRS beneficiaries, to determine what percentage of them live within TRICARE's Prime Service Areas (areas in which the managed care contractors are required to establish and maintain sufficient networks of civilian providers). According to these data, as of August 31, 2010, over 80 percent of Selected Reserve members and their families lived in Prime Service Areas: 100 percent in the South region, which is all Prime Service Areas, and over 70 percent in the North and West regions.³³

³³These percentages include members of the Selected Reserve and their dependents. Selected Reserve members living overseas, in unknown locations, and in Puerto Rico and Guam were not included in this analysis.

-
- TMA officials told us that they are repeating the *Focused Survey of TRICARE Reserve Select and Select Reserve Military Health System Access and Satisfaction*, which had first been conducted in 2008. Using results from its first survey, TMA reported to Congress in February 2009 that members of the Selected Reserve who were enrolled in TRS were pleased with access and quality of care under their plan. However, as we have noted, the response rate for this survey was almost 18 percent, although TMA took steps to adjust the data prior to reporting the results. Officials told us that the follow-up survey will focus on whether access to care for TRS beneficiaries has changed. Officials sent the survey instrument to participants in January 2011. Officials told us that they anticipate results will be available during the summer of 2011.

Conclusions

TRS is an important option for members of the Selected Reserve. However, educating this population about TRS has been challenging, and despite efforts by the reserve components and the contractors, some members of the Selected Reserve are likely still unaware of this option. Most of the reserve components lack centralized accountability for TRS education, making it unclear if all members are getting information about the program—a concern that is further exacerbated by the lack of awareness about the TRS education policy among officials from some of the reserve components. Additionally, the contractors' limitations in briefing all of the units in their regions about TRS make each component's need for a central point of contact more evident. Without centralized accountability, the reserve components do not have assurance that all members of the Selected Reserve who may need TRS have the information they need to take advantage of the health care options available to them.

Recommendation for Executive Action

We recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Reserve Affairs to develop a policy that requires each reserve component to designate a centralized point of contact for TRS education, who will be accountable for ensuring that the reserve components are providing information about TRS to their Selected Reserve members annually. In establishing responsibilities for the centralized points of contact, DOD should explicitly task them with coordinating with their respective TRICARE Regional Offices to ensure that contractors are provided information on the number and location of reserve component units in their regions.

Agency Comments and Our Evaluation

In commenting on a draft of this report, DOD partially concurred with our recommendation. (DOD's comments are reprinted in app. III.) Specifically, DOD agreed that the Assistant Secretary of Defense for Reserve Affairs should develop a policy that requires each of the seven reserve components to designate a central point of contact for TRS education that will be accountable for providing information about TRS to their Selected Reserve members annually. However, DOD countered that each designee should coordinate the provision of reserve unit information through the TRICARE Regional Offices rather than communicating directly with the TRICARE contractors, noting that the TRICARE Regional Offices have oversight responsibility for the contractors in their respective regions. We understand the department's concern about coordinating contractor communications through the TRICARE Regional Offices, and we have modified our recommendation accordingly. DOD also provided technical comments, which we incorporated where appropriate.

We are sending copies of this report to the Secretary of Defense and other interested parties. The report also is available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Key contributors to this report are listed in appendix IV.



Randall B. Williamson
Director, Health Care

Appendix I: TRICARE Management Activity Analysis of Claims

We asked the TRICARE Management Activity (TMA) to conduct an analysis of claims filed for TRICARE Reserve Select (TRS) beneficiaries and TRICARE Standard and Extra beneficiaries. We requested claims data for the most recent three complete fiscal years—2008, 2009, and 2010—based on the fact that the program last experienced changes with eligibility and premiums in fiscal year 2007.¹ For the purpose of this analysis, claims consist of all services provided by a professional in an office or other setting outside of an institution. Records of services rendered at a hospital or other institution were excluded from this analysis. In addition, records for medical supplies and from chiropractors and pharmacies were also excluded. We asked TMA to conduct the following comparative analyses for TRS beneficiaries and TRICARE Standard and Extra beneficiaries:

1. Demographics, including age for each year and averaged over 3 years
2. Percentage of claims filed for primary care, mental health, and other specialists each year for 3 years
3. The top 10 procedures in ranking order made each year and the average over 3 years
4. The top 10 primary diagnoses in ranking order made each year and the average over 3 years
5. The top five provider specialties in ranking order visited each year and the average over 3 years
6. Percentage of claims filed for the top five provider specialties and the average over 3 years

To ensure that TMA's data were sufficiently reliable, we conducted data reliability assessments of the data sets that we used to assess their quality and methodological soundness. Our review consisted of (1) examining documents that described the respective data, (2) interviewing TMA officials about the data collection and analysis processes, and (3) interviewing TMA officials about internal controls in place to ensure that data are complete and accurate. We found that all of the data sets used in this report were sufficiently reliable for our purposes. However, we did not independently verify TMA's calculations.

¹Claims filed for fiscal year 2010 may not be complete because individuals have up to 1 year to file a claim.

Appendix II: Claims Filed for TRICARE Reserve Select and TRICARE Standard and Extra Beneficiaries

Tables 2 through 5 contain information on claims filed for TRICARE Reserve Select and TRICARE Standard and Extra beneficiaries.

Table 2: Percentage of Claims Filed for TRICARE Reserve Select (TRS) and TRICARE Standard and Extra Beneficiaries by Age of Beneficiary, Fiscal Years 2008 through 2010

Age	Sex	TRICARE Standard and Extra				TRS			
		FY 2008	FY 2009	FY 2010	Total	FY 2008	FY 2009	FY 2010	Total
Under 18	Female	9.3	9.4	9.8	9.5	16.8	16.4	16.0	16.3
	Male	10.0	10.3	10.9	10.4	20.6	20.0	19.8	20.0
18-24	Female	4.4	4.7	5.0	4.7	6.3	6.7	7.0	6.8
	Male	1.8	1.9	2.0	1.9	4.0	4.1	4.5	4.3
25-29	Female	1.7	2.0	2.3	2.0	5.9	7.3	7.8	7.3
	Male	0.3	0.3	0.4	0.3	4.1	4.9	5.4	5.0
30-35	Female	2.2	2.3	2.6	2.4	7.4	7.7	7.8	7.7
	Male	0.3	0.3	0.3	0.3	4.0	4.5	4.7	4.5
36-40	Female	2.8	2.8	2.8	2.8	6.6	6.1	5.5	5.9
	Male	0.4	0.3	0.4	0.4	4.1	3.8	4.2	4.0
41-45	Female	4.4	4.1	3.9	4.2	5.4	5.1	4.8	5.0
	Male	1.2	1.1	1.0	1.1	3.7	3.2	3.1	3.2
Over 45	Female	41.2	40.3	39.0	40.1	6.7	5.9	5.5	5.9
	Male	20.2	20.1	19.7	20.0	4.5	4.4	4.0	4.2
Total		100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: GAO analysis of TRICARE Management Activity data.

Table 3: Percentage of Claims Filed for TRICARE Reserve Select (TRS) and TRICARE Standard and Extra Beneficiaries by Mental Health Care, Primary Health Care, and Other Types of Specialty Care, Fiscal Years 2008 through 2010

	TRICARE Standard and Extra				TRS			
	FY 2008	FY 2009	FY 2010	Total	FY 2008	FY 2009	FY 2010	Total
Mental health care	6.8	6.6	6.7	6.7	7.1	6.6	6.7	6.7
Other specialty care	54.5	54.8	54.8	54.7	49.9	49.4	49.4	49.5
Primary health care	38.7	38.6	38.5	38.6	43.0	44.1	43.9	43.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: GAO analysis of TRICARE Management Activity data.

**Appendix II: Claims Filed for TRICARE
Reserve Select and TRICARE Standard and
Extra Beneficiaries**

Table 4: Percentage of Claims Filed for TRICARE Reserve Select (TRS) and TRICARE Standard and Extra Beneficiaries by Top 10 Diagnoses in Ranking Order, Fiscal Years 2008 through 2010

Rank	TRICARE Standard and Extra		TRS	
	Diagnoses	Percentage of services	Diagnoses	Percentage of services
1	Allergic rhinitis ^a	12.1	Allergic rhinitis	14.2
2	Joint disorder neck and nose	4.8	Health supervision child ^b	5.5
3	Back disorder neck and nose	3.5	Joint disorder neck and nose	4.5
4	Essential hypertension ^c	2.3	Back disorder neck and nose	3.0
5	Affective psychoses ^d	2.2	Adjustment reaction ^e	2.3
6	Peripheral Enthesopathies ^f	2.1	Special examinations ^g	2.1
7	Health supervision child	2.1	Affective psychoses	1.8
8	Diabetes mellitus ^h	1.7	Asthma ⁱ	1.8
9	Adjustment reaction	1.7	Acute upper respiratory infections of multiple or unspecified sites	1.6
10	Special examinations	1.7	Suppurative and unspecified otitis media ^j	1.5
	Other diagnoses ^k	65.7	Other diagnoses	61.7

Source: GAO analysis of TRICARE Management Activity data.

^aAllergic rhinitis is a collection of symptoms, mostly in the nose and eyes, which occur when inhaling an allergen, such as dust, dander, or pollen.

^bHealth supervision of a child refers to the routine medical examination of an infant or child.

^cEssential hypertension refers to high blood pressure with no identifiable cause.

^dAffective psychoses is a group of mental disorders, usually recurrent, in which a severe disturbance of mood is accompanied by one or more of the following: delusions, perplexity, disturbed attitude to self, or disorder of perception and behavior.

^eAdjustment reaction refers to the reaction to chronic stress, including grief and prolonged depression.

^fPeripheral Enthesopathies refers to a group of disorders of muscles and tendons and their attachments, such as rotator cuff syndrome.

^gSpecial examinations refers to routine exams, such as examinations related to vision care, dental care, and pregnancy tests or other gynecological examinations

^hDiabetes mellitus comprises a group of heterogeneous disorders that have an increase in blood glucose concentrations. The current classifications for diabetes mellitus Types 1 through 4.

ⁱAsthma is an inflammatory disorder of the airways, which causes attacks of wheezing, shortness of breath, chest tightness, and coughing.

^jSuppurative and unspecified otitis media refers to a group of disorders related to the ear, such as the rupturing of the ear drum.

^kOther diagnoses include any claims filed for medical diagnoses not outlined as top 10 diagnoses above.

**Appendix II: Claims Filed for TRICARE
Reserve Select and TRICARE Standard and
Extra Beneficiaries**

**Table 5: Percentage of Claims Filed for TRICARE Reserve Select (TRS) and
TRICARE Standard and Extra Beneficiaries by Top Five Provider Specialties, Fiscal
Years 2008 through 2010**

Provider specialty	TRICARE Standard and Extra	TRS
Family practice	15.7	16.0
Physical therapist	11.6	10.8
Allergy	9.8	13.6
Internal medicine	8.9	5.1
Pediatrics	6.8	14.7
Other specialties	47.2	39.9

Source: GAO analysis of TRICARE Management Activity data.

Appendix III: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

May 18, 2011

Mr. Randall B. Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

This is the Department of Defense response to the Government Accountability Office (GAO) draft report, "DEFENSE HEALTH CARE: DoD Lacks Assurance That Selected Reserve Members Are Informed About TRICARE Reserve Select," dated April 21, 2011 (GAO Code #290870/GAO-11-551). The response is provided in two sections: 1) Response to the GAO's recommendation, and 2) Technical Comments.

The points of contact are Mr. Brian Smith (Primary Action Officer) and Mr. Gunther Zimmerman (TRICARE Management Activity Audit Liaison). Mr. Smith may be reached at (703) 681-7842, or Brian.Smith@tma.osd.mil. Mr. Zimmerman may be reached at (703) 681-4365, or Gunther.Zimmerman@tma.osd.mil.

Sincerely,

A handwritten signature in black ink, appearing to read "Jonathan Woodson", is located below the "Sincerely," text.

Jonathan Woodson, M.D.

Attachment:
As stated

GOVERNMENT ACCOUNTABILITY OFFICE DRAFT REPORT
DATED APRIL 21, 2011
GAO CODE # 290870/GAO-11551

**“DEFENSE HEALTH CARE: DOD LACKS ASSURANCE THAT SELECTED
RESERVE MEMBERS ARE INFORMED ABOUT TRICARE RESERVE SELECT”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE GOVERNMENT ACCOUNTABILITY OFFICE
RECOMMENDATIONS**

RECOMMENDATION: The Government Accountability Office recommends that the Secretary of Defense direct the Assistant Secretary of Defense for Reserve Affairs to develop a policy that requires each reserve component to designate a centralized point of contact for TRICARE Reserve Select (TRS) education, who will be accountable for ensuring that the reserve components are providing information about TRS to their selected Reserve members annually. In establishing responsibilities for the centralized points of contact, the Department of Defense (DoD) should explicitly task them with coordinating with the respective contractors to provide information on the number and location of reserve component units in their regions.

DOD RESPONSE: The DoD partially concurs with this recommendation. The DoD agrees that the Assistant Secretary of Defense for Reserve Affairs should develop a policy that requires each of the seven Reserve components to designate a central point of contact for TRS education, who will be accountable for providing information about TRS to their selected Reserve members annually. However, each designee should coordinate with the TRICARE Regional Office (TRO) to provide information on the number and location of reserve component units in their region, rather than contacting TRICARE contractors directly. TROs are responsible for oversight of their respective contractors and can ensure the contractors are performing requirements as specified in their respective contracts.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director; Danielle Bernstein; Susannah Bloch; Ashley Dean; Lisa Motley; Jessica Smith; and Suzanne Worth made key contributions to this report.

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